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MODELS OF DELIVERY OF MENTAL HEALTH SERVICES TO THE COMMUNITY IN THE 1970'S

Address to

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American Psychiatric Association

Session VII: Patterns of Delivery of
Mental Health Services

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by

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The first proposition which I want to underline very strongly here this morning is that we cannot deal with the delivery of mental health services to our people in a kind of vacuum separated from the current burning issue of the almost complete failure of the total health delivery system in this country. I submit that position statements by professional organizations such as the American Psychiatric Association and voluntary organizations such as the National Association for Mental Health have, in effect, concentrated on more effective delivery of mental health services without any real attempt to come to grips with the most fundamental institutional charges which are necessary in our society before we can achieve any of the lofty goals espoused in these pretentious pronunciamentos.

With characteristic directness and simplicity, Walter Reuther zeroed in on the big target when he told the American Public Health Association last November:

> "What we have, in fact, is a disorganized, disjointed, antiquated, obsolete, non-system of health care."

Despite three decades of effort by our commercial insurance companies and Blue Cross-Blue Shield, thirty million Americans still have no health insurance at all. In their publicity, the insurance spokesmen make much of the fact that four-fifths of the population has health insurance of one description or another, but they do not point out that two-thirds of the costs of personal health care in America are still uninsured.

Turning to the public sector, we hear much these days of the vast improvements generated by Medicare and Medicaid. The Medicare legislation has the virtue of being more precise and more sensibly financed but, because of deductibles, co-insurance, limitation of benefits and non-coverage of drugs outside of the hospital, even Medicare pays only 40 percent of the total medical bills of the average elderly person. Furthermore, as many of you know, it discriminates invidiously against the psychiatric patient in a number of settings.

Medicaid is poorhouse legislation of the worst sort. Theoretically, it is supposed to cover the medically indigent of all ages who are not necessarily on welfare, but whose low incomes make it impossible for them to afford the soaring costs of medical care. In actual practice and by specific direction of the House Ways and Means Committee, it has been converted into another aspect of welfare medicine. As a matter of fact, in most states today it is only covering people on welfare, and quite a few of these are doing it less adequately than the former categorical medical assistance programs.

Let me give you one statistic that brings the point home – of the 45 million people at or below the poverty line in this country, only about 7-1/2 million received Medicaid assistance in 1968.

Medicaid assistance for elderly mental patients is a cruel hoax. In most states, monies designated by law for the improvement of the care of elderly mental patients in state hospitals go into the state general revenue fund and are seldom seen by the hospitals. As a further vote of confidence in this "magnificent" program, the Nixon Administration has proposed that Medicaid payments for elderly mental patients be reduced from full yearly coverage to 120 days per year. I have tried to work up a degree of anger about this proposal, but I have not succeeded – the entire program so reeks of eleemosynary medicine that I cannot weep for any cutbacks in it.

Last year the Blue Cross Association, concerned with mounting public criticism of the inadequacies of health insurance, commissioned the pollster Lou Harris to do an in-depth sampling of the American people to either validate or refute these contentions. The Harris survey was the most complete of its kind ever conducted, including home interviews with more than one thousand people in all parts of the land.

The results of the Harris survey, as published last December by the Blue Cross Associa-

tion, can only be described as shocking. Most of the respondents to the inquiry, whether poor or affluent, felt themselves isolated from good medical care. A majority reported that they would not know where to turn in the event of a serious illness in the family. From all of the accumulated evidence, the Harris survey concluded:

> "Now in the affluent 60's...it can truthfully be said that over one-third of this nation feels ill-cared for in its medical needs."

In the public sampling, more than half of the American people gave health a higher priority than having a good job and, among poverty groups, 72 percent of poor whites and 59 percent of poor blacks rated good health over a job or money.

Large segments of our population exhibit the deepest anxieties and frustrations when asked about the accessibility of good health care. Two-thirds of the general public feel that you can't get a doctor in an emergency; 40 percent of the general public, and two-thirds of the poor, worry that they will be unable to pay a doctor if they can locate one, and more than half of the general public, and two-thirds of the poor, told interviewers that they were terrified of a serious illness which would disable the breadwinner and wipe out all family savings.

The section on health care of the poor should be read, and re-read, by every member of this audience.

"The health of the poor in the United States is a national disaster", says Dr. Jack Geiger, Professor of Preventive Medicine at Tufts University School of Medicine. Dr. Geiger runs an OEO Health Center in Mound Bayou, Mississippi, where the local pharmacy dispenses food as prescription medicine at Dr. Geiger's insistence.

According to a recent report of the National Center for Health Statistics, which sampled the incidence of illness among 45 million Americans at or below the poverty line, these people

had four times as many heart conditions as those in the highest income groups; six times as much mental and nervous trouble; six times as many cases of high blood pressure, and so on.

In a quite imaginative departure, the Harris survey did a series of in-depth interviews on psychosomatic complaints. Its findings in this area are truly startling. For example, here are some responses to a question as to whether people "sometimes feel" any of the following symptoms:

	Total Public	Poor
Worried and nervous	60%	65%
Lonely and depressed	52%	58%
Unable to sleep	33%	39%
Emotionally disturbed	23%	27%

In all of the detailed documentation, the poor and the near poor report a very high incidence of nervous tension, back troubles, ulcers, high blood pressure, indigestion, insomnia, and exhaustion. They trail the affluent in only three disease areas which they obviously can't afford —sunburn, allergies and acne. In other words, the rich have certain "respectable" diseases which the poor would like to have, but cannot yet aspire to in the economic pecking order.

I have purposely recited this litany of despair from both the Harris survey and the National Center for Health Statistics because it is the most vivid illustration I know of the extent of psychological distress among the good people of our land. Furthermore, how much mental illness is produced by these terrifying anxieties among our people – the almost endemic fear that they will be unable to pay their doctor bills, or the crushing and pervasive foreboding that a major disease such as mental illness will wipe out the savings of a lifetime and leave a wife and children unprotected. When we talk about the etiology of emotional disturbances at comfortable conferences, we seldom mention these diffuse and corrosive worries which literally disable so many of our citizens.

I am not unaware that we have made considerable progress in better psychiatric coverage for some segments of our population. A decade ago Walter J. McNerney, President of the Blue Cross Association, referred incisively to the lack of purchasing power of mental patients as a major deterrent to innovation and experimentation with increased insurance coverage. In the intervening years, avenues of payment for psychiatric treatment have increased appreciably through expansion of psychiatric coverage in health insurance policies and, more importantly, through labor-negotiated benefits. As Mel Glasser has pointed out, it is more impressive that 15 million people have become eligible for psychiatric insurance benefits during the past three years through union efforts. The community mental health center legislation has also contributed to a considerable degree in bringing previously remote psychiatric care within the reach of our low-income groups. This progress is very heartening but, in many ways, the proliferation of payment resources adds options which accentuate the invidious differences in coverage among large segments of our people.

At the present time, we have a diversity of health systems which confuse the consumer and make continuity of care almost a bravura achievement. In theory, the mental patient has a number of treatment gates through which he may enter – traditional and entrenched private office practice; group practice in some of our larger cities; the state mental hospital; 2,000 local mental health clinics; community mental health centers; OEO centers; Partnership for Health Neighborhood Centers, and many more.

In actual fact, the nagging worry about inability to pay – or the refusal to take charity medicine – severely circumscribes these options.

I have commented on previous occasions, both before this distinguished organization and at meetings in all regions of the country, on the unbelievable chaos perpetuated by the health insurance industry in its coverage of mental illness. At the present time, despite innumerable conferences over the years on health insurance coverage of mental illness sponsored by both professional and lay organizations, it is a demonstrable fact that insurance payments for mental illness continue to be largely conditioned upon the geographic accident of where a patient lives. It still strikes me as utterly fantastic that, even within an individual state, varying Blue Cross plans run the gamut from no coverage for mental illness to 90 days of coverage and up.

When you move out from the hospital bed to ambulatory care in the community, the situation approximates actuarial madness. Despite an impressive body of experience in recent years on the low rate of utilization of available psychiatric care, it is painfully evident that most plans provide little or no coverage for patients in a psychiatrist's office, or in a community mental health center. For example, we hear much trumpeting from the insurance industry about the glories of major medical plans covering long-term illnesses, but here again the coverage of mental illness is discriminatory and characterized by a mixed bag of deterrents – yearly deductibles running anywhere from $25 to $500; high co-insurance requirements; lifetime limitations of pay-outs for mental illness running as low as $2,000, and many more which illustrate graphically the industry's suspicion of the "malingering" mental patient.

Much of this data is contained in the excellent 1968 Insurance Report of your own Joint Information Service which, judging by conversations with many of your brethren, has been almost completely ignored. That meticulous study pointed out that, of approximately 14,500 patients going to priviate psychiatrists, only about one in four had any coverage for mental illness. Furthermore, of those who were "protected" – approximately 3,350 – two-thirds had to pay 50 percent or more of the costs.

Fifteen years ago, testifying before a Joint Committee of the New York State Legislature

holding hearings on health insurance, I made this rather radical suggestion:

> "If the insurance companies of America cannot cover the most prevalent illness in the nation in their basic policies, they really forfeit the right to the patronage of the people."

Without attempting to shock this ancient and conservative organization, I submit that the statute of limitations has run out, and the insurance industry has forfeited this right.

Having visited some 25 community mental health centers over the past several years, I have come to the conclusion that the uncertainties in financing mandated services is probably the most pressing problem since we inaugurated this program in 1963. The precipitious decline in federal support for staffing of these centers – a drop of 75 percent to the zero point in less than five years – threatens the survival of many existing centers and chills the ardor of communities which desperately want a center, but realize that the financial inconstancies are too great. Some are reluctant to start a center today because of the continuing resistance of the private health insurance industry to covering outpatient psychiatric care, the severe slashes in the Medicaid program over the past several years, and other equally disturbing developments.

For more than a year now, I have pleaded with the Division of Mental Health Service Programs of the National Institute of Mental Health to begin the job of collecting data which is available on the various third party and public payments which are financing these centers today. I have talked to a dozen state mental health commissioners who say they would eagerly welcome such a survey, but they have received no inquiries from the National Institute of Mental Health. I am running out of patience on this issue.

To my way of thinking, it is quite frustrating that both the federal government and many

private organizations still go through the ritual of developing hortatory guidelines for health insurance coverage, but turn up very little hard evaluative data to either approve or disapprove the validity of these guidelines.

For example, President Kennedy, in the conversations we had with him leading up to the drafting of the landmark Community Mental Health Center legislation, was acutely aware of the deficiencies of private health insurance in covering mental illness; he was quite concerned with the inability of many communities to support these centers. In 1963, he therefore instructed the Secretary of Health, Education, and Welfare to appoint a Task Force on Insurance to study these key financial problems and make concrete recommendations. The Task Force dutifully carried out its mission and, in 1964, released a report urging the health insurance industry to move into the area of partial hospitalization, more extensive coverage of psychiatric care in the community mental health center or in the private psychiatrist's office, coverage of drug expenses for ambulatory patients, and so on. I have no argument with the major thrust of these recommendations, but may I point out that five years have gone by and not one of them has been put into practice on a widespread scale.

I am also well aware of the fact that the American Psychiatric Association has been wrestling with this problem of financing. You held a two-day conference last December 13th and 14th devoted to "the Association's role in the decades ahead in helping to shape the provision of adequate health care services for our nation's citizens."

I don't mean to be unkind, but I found little new in the lengthy summary of that conference published in the April issue of PSYCHIATRIC NEWS. The major proposal seemed to be a rather vague extension of existing voluntary health insurance which would somehow eventuate into a "national health care insurance program with coverage provided by independent insurance carriers." I have had more than 20 years

of dealing with all kinds of Rube Goldberg proposals entailing putting various kinds of financial carrots before the health insurance industry; not one has worked. Since the author of the proposal knows in his heart that even a bushel of carrots won't get the health insurance industry to move into coverage of low-income groups, he proposes special government financed care for the indigent with an "applied means" test. Doesn't he realize that we have such a mess today – it is known as Medicaid – and its ceilings for coverage are practically at the welfare level? Furthermore, this "applied means" test business doesn't sit very well with American labor; it is another degrading aspect of charity medicine.

The conference also gave considerable emphasis to that hoary Republican chestnut – income tax credits for health insurance premiums. I won't belabor the point that this proposal is very good for the affluent, but Marie Antoinette lost her head for proposing it in the late 18th Century.

Following upon this conference, your organization recently released the second edition of "APA Guidelines for Psychiatric Services Covered under Health Insurance Plans". In perusing it, I note that you come out for usual and customary fees for doctors' services. The report emphasizes that it thus endorses this fee concept as defined by the House of Delegates of the American Medical Association. Knowing something of the AMA's truly progressive record on Medicare and other health legislation, I hope that as psychiatrists you have examined clinically the sequelae of getting into bed with such promiscuous liberals.

I must confess that I find your position an astounding one. Usual and customary fees as translated into practice mean all that the market will bear; Medicaid today is in financial bankruptcy because a number of doctors have pocketed outlandish sums of money under the old Robber Baron theory. I know that you have been much too busy holding conferences to study the sorry

history of Medicaid, but President Nixon has not. In the proposed new regulations for Medicaid, the President establishes fee schedules for physicians based upon the lowest prevailing Blue Shield rates.

At the aforementioned December conference, one group which dealt with the issue of fees for physicians' services suggested that "the American Psychiatric Association should come out with a general statement sometime in the near future regarding the desirability of all its members exercising restraint in raising fees or increasing their income". I am glad that you have now joined with the Department of Health, Education, and Welfare, the Congress, many state legislatures, and a growing number of medical statesmen in endorsing monetary restraint. On the basis of this revolutionary declaration, I expect you in the near future to endorse motherhood, a nine-month pregnancy and free beer.

I agreed with very little that Eli Ginzberg said at the December conference, but on one observation I am on all fours with him:

> "It is crystal clear to me that the American public cannot sustain public financing on a fee for service basis. That is the fundamental error of Medicaid... It won't work. It doesn't work. It doesn't make any sense either. So we will have more and more scheduled fees."

In pointing up some of the obvious deficiencies of our current health delivery system, I do not want to belittle the diversity and experimentation which has characterized the considerable extension of psychiatric care during the past decade.

We are participating in an exciting revolution in which labor-negotiated benefits, community mental health centers and other developments are extending the benefits of psychiatric therapy to millions of our people whom it never touched before. The papers delivered at this

panel this morning illustrate beautifully this new smorgasbord of services. Mr. Glasser's paper on prepaid psychiatric care experience with UAW members, and Dr. Green's paper on the use of the Kaiser-Permanente Organization in Southern California in providing psychiatric services for the Retail Clerks Union, are eloquent evidences of the movement toward coverage of union members which now also encompasses the United Steelworkers of America and a number of smaller unions. The paper on the Oaklawn Psychiatric Center in Indiana is a fascinating discussion of how a private psychiatric hospital has extended its services through contractual agreement with six counties in Indiana and Michigan to provide a broad range of day hospital, home treatment and other services.

The report by Drs. Leopold and Kissick on the first 21 months of the West Philadelphia Community Mental Health Consortium is a superbly documented picture both of the out-reach potentials of a community mental health center in developing satellite neighborhood clinics and the remarkable degree of cooperation with the regional medical program for heart disease, cancer and stroke and with the newly formed Department of Community Medicine at the University of Pennsylvania.

However, implicit or explicit in several of these studies is the underlying frustration in delivering psychiatric services under a leaky umbrella of varying matching formulas and consequent financial uncertainties. Noting that "the health delivery system remains fragmented not only in funding, but in coherent program development as well", the West Philadelphia authors quote this incisive observation from the distinguished editor Gerard Piel, Chairman of the New York City Commission on the Delivery of Professional Health Services:

> "The laissez-faire market processes cannot successfully organize the modern technology required for the delivery of comprehensive professional health services."

Our current experimentation in delivery of health services is commendable, but it is almost totally circumscribed by the financial vagaries of the governmental agency or the private sector group funding the resources. As a result, you see a polarization of coverage running the gamut from very good coverage in the United Auto Worker's contract to the opposite extreme in which most private and non-profit carriers still resist coverage of ambulatory psychiatric care.

The community mental health center program, even granting to it all the virtues which your President, Dr. Kolb, and I have ascribed to it in recent orations, is a rather frightening exemplar of the chaotic nature of our present financial support of psychiatric services. If you agree with me that the federal matching subsidy for the staffing of these centers is an awkward artifice created by a suspicious Congress, and if you go one step further with me and grant that this staffing subsidy really exists in lieu of mass purchasing power by the clients of the center, then how do you make these centers economically self-sufficient when the federal subsidy ends?

The present system is obviously unsatisfactory. Some centers at the present time have eligibility rules and sliding scales of payment which have no justification in an ordered universe. Furthermore, except in those centers sponsored and run by departments of psychiatry in the inner city, low-income groups in many areas of the country, both urban and rural, are still not being reached by the centers program because the matching monies are not available.

By the same token, under Medicaid, coverage of mental illness depends upon what a particular state government chooses to allocate; the poorer states, which need mental health services the most, are doing the least satisfactory job. In other words, a conglomeration of varying formulas, rigid rules for eligibility and other clumsy yardsticks perpetuate unjustifiable distinctions between rich and poor, between those who have political clout and those who have none, and between various sections of the country.

It is the fundamental thrust of this paper that any discussion of models of delivery of mental health services in the coming decade is unrealistic until we devise a universal mechanism for payment of these services. If we do not go about the business of developing a national plan, we will witness in the near future an even greater multiplicity of competing kinds of payments which will only further confuse the mental patient.

The most logical answer to the present chaos and confusion is national health insurance. I do not mean a feeble downward extension of Medicare which is fundamentally directed, as Selig Greenberg has noted, toward covering hospital and doctor charges and avoids the crucial problem of insisting upon a high quality of care, including preventive services. Medicare is another form of sickness insurance – it bleeds only when the patient bleeds. Health insurance concerns itself with prevention, early intervention and maintenance of health. It can draw upon the rich actuarial experience of the insurance industry and it can, and should, guarantee the patient complete freedom of choice in selecting the provider of care under traditional fee-for-service or other payment mechanisms. However, learning from the shortcomings of Medicare and Medicaid, the government must set standards for the private sector of medicine which mandate a high quality of specifically spelled-out comprehensive psychiatric services, and it must insist upon negotiated fee schedules with maximum payments clearly stated.

Every other major country in the world has some form of national health insurance. In America, the first national health insurance bill was introduced in the Congress by Senator Robert Wagner in 1939. It is an idea whose time has now come.

I want to stress, even though it is almost inevitable that I will be misunderstood, that I am proposing no basic changes in the current practice of psychiatry. I have no intention of interfering with what the American Medical Association has described as "the sacred patient-doctor relationship", whose main rite of sanctification is the therapeutic transference of money from the victim to the doctor.

I want to emphasize just as strongly that I am not proposing a form of socialized medicine. We have had almost two centuries of socialized medicine exemplified by our state hospital system, and it has not worked. I do not advocate government salaried doctors, nor do I want government at any level running our mental health centers.

Over the past 15 years, I have tried in every way possible to extend the reach of the private sector of psychiatry. I am now convinced that we can only do this by devising a sound, universal financial floor for all mental health services in either the public or the private sector.

In very simple terms, national health insurance is merely a mechanism of payment – not a theological doctrine. Under the Social Security system, we have restricted its benefits to our citizens over 65 years of age; it is now about time that we finished the job.

I have come to this conclusion because I can no longer abide the invidious and discriminatory nature of our present system. All consumers must have the economic means to purchase the psychiatric care they need – not just those fortunately part of a progressive union, or located near a medical school, or whatever.

Just one final comment. I am known in some circles as an advocate of the community mental health center program. However, I am convinced that the present precarious and bewildering financing of existing centers portends a serious crisis unless a universal method of payment for psychiatric services is devised. I therefore plead with the American Psychiatric Association, which has done so many progressive things in the past, to come to grips with the real issue – the smoldering discontent of the American people from all economic strata with our present

non-system of health delivery. You took the first steps last December, but I urge you to draw a deeper breath and assess the need for national health insurance without any of the perceptual biases, scare words and shibboleths which have cursed discussions of this problem in the past.

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